BAY RADIOLOGY San Ramon

Patient History Questionnaire (MRI)

Patient Name:_____ Date:_____

Reason for Procedure:

Please check any of the following symptoms that you are experiencing:

☐ Chest pain ☐ Headaches ☐ Nausea ☐ Hearing loss

☐ Abdominal pain ☐ Blackouts ☐ Blurred vison ☐ Ringing in ears

☐ Pelvic pain ☐ Dizziness ☐ Memory loss ☐ Seizures

☐ Back pain ☐ Neck pain ☐ Unexpected weight loss

☐ Shoulder pain-(☐ Right/☐Left) ☐ Numbness-(☐ Right side/☐ Left side)

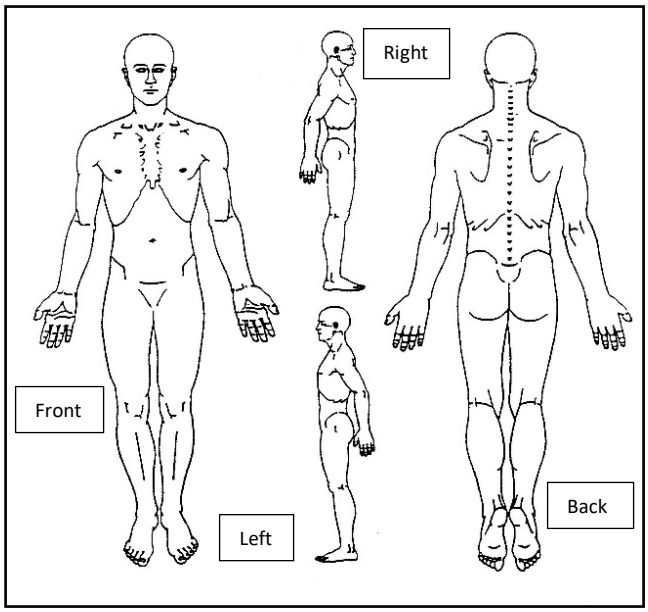
☐ Leg pain-(☐ Right/☐Left) ☐ Weakness-(☐ Right side/☐ Left side)

☐ Arm-(☐ Right/☐Left) ☐ Other:_____

How and when did these symptoms occur (e.g., injury, just started, ect.)?

_____

_____



Please identify the location of any pain/numbness/limp

Medical History:

1. Do you have or have you had any of the following?

☐ Cancer ☐ Heart disease ☐ Kidney/renal disease ☐ Multiple myeloma ☐ Hypertension

☐ Seizures ☐ Sickle cell anemia ☐ Tumor, lump or mass ☐ Bleeding tendency ☐ Heart arrhythmia

☐ Diabetes ☐Congenital heart defect ☐ Glaucoma ☐ Stroke

☐ Asthma, bronchitis or emphysema ☐ Other illness/disease:_____

2. Have you had any tests (MRI, CT, X-Ray, ect.) performed for the symptoms you are currently experiencing? ☐ Yes ☐ No
If yes, please list the date and type of surgery or therapy:_____

_____

3. Have you had any surgeries or therapies (e.g., radiation therapy, chemotherapy, ect.)? ☐ Yes ☐ No
If yes, please list the date and type of surgery or therapy:_____

_____

4. Are you currently taking any medications? ☐ Yes ☐ No
If yes, please list all medications you are currently taking:_____

_____

5. Do you have any allergies (e.g., medications, latex, food, ect)? ☐ Yes ☐ No
If yes, please list all allergies:_____

_____

I hereby certify that the above information is true and correct to the best of my knowledge.

_____ _____ _____

Patient or Legal Representative Signature Print Name and Authority (life legal representative) Date

Technologist Notes:_____

_____

_____